Agency/Clinic: _____ **Audit Date:** _____ **Auditor:**_____

Montana WIC Program Administrative Chart Audit

Participant ID Number										
Household ID Number										
Certification: Start End										
First Name Last Name										
DOB										
Category										
Served within time frame?										
Participant ID?										
Representative ID?										
Residency Documented?										
Income Documented?										
Adjunctive Eligibility?										
Verified in SIS?										
Notice of Cert End?										
Notice of Ineligibility?										
Benefits Signed for?										
Mailed? *Verify mail log(on-site) Proxy Note?										
Voided Benefits? *Verify procedure										
Comments:										